NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAID SERVICES AUDIT AUDITOR GUIDELINES
2010

Q1 – Service Authorization:

- If the provider does not have evidence of authorization from ValueOptions (VO), check for service authorization that covers the date of service being reviewed on the spreadsheet provided by VO (on computer – see a team leader).
- **Rating:**
  - If authorization is present, rate Q1a = "4".
  - If no authorization**,** rate Q1a = "0".
  - **If Q1a is rated "0", enter dates in Q1b. FROM is the first date when there was no valid authorization, or 7/1/09; TO is the last date there was no valid authorization or the date of the audit**, if there is still no authorization.

Q2 – Service Order:

- Appropriate service has been ordered. **The service needs to be identified in the Action Plan** of the PCP to be ordered via signature on the PCP. Separate service order forms are not acceptable.
- **Dated Signatures** :
  - Medicaid-funded services must be ordered by a **licensed MD or DO, a licensed psychologist, a licensed nurse practitioner or a licensed physician's assistant.**
  - Both the signature and date must be **handwritten by the signatory**.
  - **Dates may not be entered by another person or typed in**.
  - **No stamped signatures** unless there is a verified Americans with Disabilities Act (ADA) exception.
  - A service order may not be obtained (signature on the PCP) before the PCP is completed. **Service order signatures dated prior to the Date of Plan on the PCP will render the service order invalid**.
- When the **PCP is reviewed/updated, but no new service is the result**, the signature for the service order is not required unless it is time for the annual review of medical necessity.
- For audit purposes, the **Service Order is signed on or before the date of service, but never before the Date of Plan**.
- No Introductory PCP's after March 1, 2010.
- Effective February 1, 2010, PSR could write their own PCP's.
- **Rating:**
  - If service order is present, rate Q2a = "4".
  - If no service order**,** rate Q2a = "0".
- **If Q2a is rated "0", enter dates in Q2b**. **FROM is the date of the PCP, (no earlier than 7/1/09). TO is the date a valid service order went into effect, or the date of the audit**.

Q3 – PCP is Current:

- The individualized PCP shall begin at admission and shall be rewritten annually and/or updated/revised:
  - If the needs of the person have changed i.e. an existing service is being reduced or terminated
  - On or before assigned target dates expire

  - When a provider changes
    - Note the provider name on face sheet, on crisis plan and in Action Plan (if there).
    - If the current provider is not reflected, it may be that the PCP was not updated when the provider changed**.**
- Target dates may not exceed 12 months.
- **Signatures & Dates**
  - **Signatures are obtained for each required/completed review, even if no change occurred.**
  - Signature verifying medical necessity (a service order) is required only if a new service is added unless it is the annual review of medical necessity.
  - Author of the PCP and the legally responsible person (lrp) have signed the PCP
    - If the legally responsible person did not sign the PCP until after the service date, there must be documented explanation and evidence of ongoing attempts to obtain the signature.
    - If no signature of the lrp and no attempts documented to obtain it, call the PCP out of compliance.
  - For audit purposes, **signatures must be dated on or before the date of service, but never before the Date of Plan.**
- Documentation of the legally responsible person, if not the parent of a minor, needs to be reviewed:
  - Court ordered guardianship or court-appointed custody to DSS.
  - If a minor is cared for by someone other than a parent, and evidence of that caretaker having the **intention for long-term care is present, that may be accepted as "in loco parentis"** in lieu of legal guardianship.
- 3a. Dates: **FROM is the first date the PCP is not valid. TO is the date a valid PCP went into effect, or the date of the audit**.
- **Rating:**
    - If PCP is current, rate Q3a = "4".
    - If PCP is not current**,** rate Q3a = "0".
    - **If Q3a is rated "0", enter dates in Q3b. FROM is the first date when the PCP was not current, or 7/1/09; TO is the date the PCP became current or the date of the audit**.

- No Introductory PCP's after March 1, 2010.
- Effective February 1, 2010, PSR could write their PCP's.
- Effective March 1, 2010, all other services may use the new format.
- Effective July 1, 2010, all other services must use the new format.

<u>Q4 – The PCP is Individualized:</u>

- PCPs and goals/interventions in particular, should be individual to the person to whom the PCP belongs.
- **Rating**
  - **4**=service(s)/support(s), goals, strategies, and interventions in the PCP reflect and are tailored to meet the individual's needs and preferences for **<u>all</u>** service(s)/support(s) listed.

- **2**=service(s)/support(s), goals, strategies, and interventions in the PCP reflect and are tailored to meet the individual's needs and preferences for **some** service(s)/support(s) listed. Others appear to be written "one size fits all" and reflect program or service requirements rather than the individual's needs and preferences.
- **0**=service(s)/support(s), goals, strategies, and interventions in the PCP do not reflect and are not tailored to meet the individual's needs and preferences. They are missing or appear to be written "one size fits all" and reflect program or service requirements rather than the individual's needs and preferences.
- **If Q4a is rated "0" enter dates in Q4b. FROM is the date of the PCP or 7/1/09; TO is the date the PCP expired or the date of the audit.**

Q5 – Documentation is Written & Signed:

- Service note is **written and signed** by the person who provided the **service (full signature, no initials).**
  - "Written" means "composed".
  - If a signature is questionable, request the provider signature log to validate signature.
- **Signature includes credentials, license, or degree for professionals; position name for paraprofessionals, which may be typed, stamped or handwritten**.
- **Rating:**
  - **4**=the documentation is written within the allowed time frame and the signature includes credentials and/or position of the person providing the service.
  - **2**=the documentation is written within the allowed time frame and signature does not include the credentials and/or position.
  - **0**=the documentation is written and/or signed after the allowed time frame or the signature is missing.
- Family members or the legally responsible person may not provide these services for reimbursement.
- If there is **no note for the date being audited**, mark this question "6 = No service note". Also mark "6" for Qs 5, 6, 7,8,. *Do not mark "6" for Q9. Q9 will be evaluated without benefit of a note for the date of service.*

Q6 – Service Note Relates to Goals

- Service note reflects purpose of the intervention
- Service note states, summarizes and/or relates to a goal or references a goal number in the current PCP.
- The goal has not expired and is not overdue for review.
- If the goal in the note does not reflect the exact language or use the right number for a goal, review the goals in the PCP to see if it relates to one of them.
- **Rating**
  - **4**=purpose documented in the service note relates to a goal listed in the PCP.

- **2**=purpose documented in the service note partially relates to a goal listed in the PCP
- **0**=no purpose included in the note or purpose documented in the service note does not relate to a goal listed in the PCP.

Q7 – Documentation Reflects Treatment for the Duration of Service:

- Service note reflects intervention/treatment
  - The intervention relates back to the stated purpose in the service note
  - If the intervention relates to a goal in the plan but it isn't the stated goal on the note, do not call out of compliance, but make a clear comment in the comment section.
- Determine that the documentation provided for a specific date of service adequately represents the number of units paid:
  - Does the intervention/treatment documented justify the amount of time paid?
  - Does the intervention documented reasonably take place in the time documented?
  - Does the intervention reflect "treatment" related to goals, symptoms and diagnoses, for the time indicated?

Rating

- **4**= the note reflects treatment for the entire duration paid.
- **2**= the note reflects treatment for more than half of the duration paid
- **0**= the note reflects no intervention or treatment for less than half of the duration paid.

Q8 Documentation Reflects Assessment of Progress towards goals:

- **Assessment of person's progress toward goals** / effectiveness for the individual (how did it turn out for the individual; how did the individual respond to the intervention?).

Rating

- **4**= there is a clear indication of the assessment of the intervention
- **2**= there is minimal indication of the assessment of the intervention
- **0**= there is no indication of the assessment of the intervention

Q9 – Service Notes are Individualized:

- Review service notes around the service date audited to determine if notes are individualized.
- **Notes should vary from day to day and person to person**, and be specific to goals in each PCP.
- The first record audited may have to be revisited if consequent notes in another record appear to be the same.
- **No Xeroxed notes with the dates and/or signatures changed**.
- **No handwritten notes copied throughout the record** with different service dates.
- **Rating**
  - **4**= service note does not match any other service note.

- **2**= service note is similar but not exactly the same as another service note.
- **0**=service note is exactly the same as another service note

Q10 – Units Billed Match the Duration of Service:

- Duration of service for periodic services must be documented.
- Billing and duration must be an exact match, however, if fewer units are billed than are documented, do not call this out of compliance.

- **Rating:**
  - 4=units paid are equal to or less than units documented.
  - 0= units paid are greater than units documented

Q11—Team Meet Staff Requirements:

Please see Attachment for Specific Service Definition Requirements and ratings.

Q12 – Qualifications and Training

- Review personnel record of all staff that provided the service.
- For all service providers, verify both education and experience, per Core Rules requirements
- Review education and training documentation for each item listed on the Qualifications Checklist.
- **If no service note/signature rate Q 12, 13, 14 and 15 as 7, "unable to identify service provider" for PSR. If ACTT or CST, rate these questions for all team members.**
- **If the staff or team member providing the service is not qualified, use the following rating:**
  - **4= staff or all team members are in compliance with qualification/training requirements**
  - **0= 1 or more team members are not in compliance with qualification/training requirements**
  - **IF this question is rated "0", enter dates in 12b. FROM is hire date or 7/1/09. TO date is the date qualifications/training are met or audit date.**

Q13 – Supervision Plans:

Individualized supervision plans are required for **paraprofessionals, associate professionals and all CS Team members except team leader.**

- **For PSR, evaluate based on names within the note. For ACTT and CST, evaluate for team members (July and August).**
- Review each supervision plan to determine frequency/duration of required supervision. **If a supervision plan is in place, rate Q13a="4".**
- Supervision plans must be implemented as written. Review documentation of supervision against the supervision plan requirements**. If the supervision plan was implemented as written, rate Q13b="4".**
- **An agency policy on supervision, even if it includes frequency/duration of supervision may not be accepted** in lieu of an individual supervision plan.
- If the supervision plan is not implemented as written, **enter the dates of non-compliance in 13c**, for example:
  - Supervision plan calls for 1/month supervision. Event date is March 12. Enter "FROM: March 1 TO: March 31, 2010" in Q13c.

  - Supervision plan calls for 1/week supervision. Event date is March 12. Ask what the work week is (i.e., Monday-Sunday). Look up corresponding dates for the week and enter in Q13c.
- Both Q13a and Q13b must be rated "4" to have an overall rating for Q13 = 4.
- If either 13a or 13b is out of compliance then the overall rating is 0.

Q14– Disclosure of Criminal Conviction/Criminal Record Check

- Review documentation showing the **provider agency required the staff that provided the service to disclose any criminal conviction**. Most frequent place to find the disclosure statement is on the employment application or on a separate form/statement filled out during the application process.
- If no disclosure is evident, a criminal record check made prior to the date of service by the provider agency is acceptable,
- If a criminal record check is evident, still ask for evidence of the disclosure. Make a recommendation or assign a POC as appropriate if disclosures are not in place.

FOR PSR:
Criminal Record Check *for staff hired on or after 3/24/05*:

- Determine date of hire.
- No criminal history record checks required for applicants that have an occupational license, i.e. MSW, MD, Nurse, etc.
- For an applicant who had been a resident of NC for **less than five (5) years**, he/she must have **consented to a State and National** (national checks conducted by the Department of Justice with finger prints) record check before conditional employment.
- For an applicant who had been a resident of NC **for five (5) years or more**, he/she must have **consented to a State** record check before conditional employment.
- The provider, within five (5) business days of making a conditional offer for employment, must submit a request to the Dept. of Justice to conduct a criminal record check. A NC county or company with access to the Division of Criminal Information (DCI) data bank may conduct the record check on behalf of the provider.
- **Most often providers will show auditors the actual criminal record check results. HOWEVER, to be in compliance with this requirement the auditor need only see the applicants consent for a CRC or the auditor may see the provider's request for a CRC. We do not need to see the results.**
- ***For purposes of the audit, the criminal record disclosure or consent to or request for a CRC must have occurred prior to the date of service reviewed.***
- **Q14c – Dates:** If the disclosure or consent or request for Criminal Record Check was not completed prior to the date of service, enter the dates in Q14c. *FROM* is the date of hire or 7/1/09, (whichever is later), *TO* is the last date before the disclosure or consent for the record check was completed, or the date of audit, if not yet completed.

Q15 – Health Care Personnel Registry (HCPR) Check:

- There may be **no substantiated finding of abuse or neglect** listed on the NC Health Care Personnel Registry for unlicensed providers.
- **Health Care Personnel Registry Checks are not required for licensed professionals.**
- 15a - **Dates:**
  - If the HCPR Check is non-existent or after the date of service, **FROM is the date of hire or 7/1/09, whichever is later, TO: is the date of the audit, the date the HCPR Check was completed or the last date of employment.**
  - If there is a substantiated finding, **FROM** is the date of the finding. **TO: is the date of the audit or the last date of employment.**

Comment Section:

- **Comment on/clarify any questions receiving ratings of 0 or 2.** There needs to be a good/factual explanation for any item rated out of compliance. For example, if Q5 is rated "0", write "#5" in the Comment Section and explain why it was rated out of compliance. **Do not repeat the question, add specific information regarding why the item was rated 0 or 2.**
- Attach copies of documentation for elements found out of compliance. **All items rated 0 and 2 must have a copy of something attached as evidence, UNLESS it is "not met" because it doesn't exist – no PCP, or no service note.** Make sure your comments explain the situation if nothing is attached.
- There are **2nd sheets** available for comments if all comments don't fit on the audit tool. Please use these sheets rather than crowding the bottom of the audit tool.

General Information

- Auditor must complete all sections of the audit sheet and will be responsible for acquiring all needed information.
- Review all tools for completeness before returning any records to the provider.
- Completed audit tools must be reviewed by a team leader prior to copying tools and releasing the provider and their records.
- ENSURE THAT NO **ORIGINAL** AUDIT TOOLS ARE GIVEN TO THE PROVIDER. The audit tools and copies will be 2 different colors.

- **Pink (Plan Of Correction) Sheets:**
  - Complete pink (POC) sheets as you go along – if you notice that something is a **systemic issue** as you are auditing, go to the pink sheet and circle the appropriate corrective action.
  - Review pink sheets when audit is complete to ensure that all areas that need corrective action are included.
  - If there is a statement that needs to be made that would not be covered by the corrective action choices, use the General Summary section – this will appear in the report.
  - If there are significant pieces of documentation not provided at the audit, use the statement at the end of the pink sheet to indicate specifically what was missing.
  - Review the required corrective action with the provider.
  - After reviewing the pink sheet with the provider, obtain the provider's signature indicating the collaborative review.

MEDICAID SERVICES
Special Requirements for Q10

**If the service audited is not listed below,
rate Q 10 = "9"**

ACTT

Staffing Requirements

Assertive Community Treatment services must be provided by a team of individuals. Individuals on this team shall have sufficient individual competence, professional qualifications and experience to provide service coordination; crisis assessment and intervention; symptom assessment and management; individual counseling and psychotherapy; medication prescription, administration, monitoring and documentation; substance abuse treatment; work-related services; activities of daily living services; social, interpersonal relationship and leisure-time activity services; support services or direct assistance to ensure that individuals obtain the basic necessities of daily life; and education, support, and consultation to individuals' families and other major supports. Each ACT Team staff member must successfully participate in the DMH approved ACTT training. The DMH approved training will focus on developing staff's competencies for delivering ACTT services according to the most recent evidenced based practices. Each ACT Team shall have sufficient numbers of staff to provide treatment, rehabilitation, and support services 24 hours a day, seven days per week.
Each ACT Team shall have a staff-to-individual ratio that does not exceed one full-time equivalent (FTE) staff person for every 10 individuals (not including the psychiatrist and the program assistant). ACT Teams **that serve approximately 100 individuals** shall employ a minimum of 10 FTE multidisciplinary clinical staff persons including:

***Team Leader*:** A full-time team leader/supervisor that is the clinical and administrative supervisor of the team and who also functions as a practicing clinician on the ACT Team. The team leader at a minimum must have a mater's level QP status according to 10A NCAC 27G .0104.
***Psychiatrist*:** A psychiatrist, who works on a full-time or part-time basis for a minimum of 16 hours per week for every 50 individuals. The psychiatrist provides clinical services to all ACTT individuals; works with the team leader to monitor each individual's clinical status and response to treatment; supervises staff delivery of services; and directs psychopharmacologic and medical services.
***Registered Nurses*:** A minimum of two FTE registered nurses. At least one nurse must have a QP status according to 10A NCAC 27G .0104 or be an Advanced Practice Nurse (APN) according to NCGS Chapter 90 Article I, Subchapter 32M. The other nurse must have at minimum an AP status according to 10A NCAC 27G .0104. By July 1, 2005, it is expected that all team nurses will be have QP Status or be APNs.
***Other Mental Health Professionals*:** A minimum of 4 FTE QP or AP (in addition to the team leader), with at least one designated for the role of vocational specialist, preferably with a master's degree in rehabilitation counseling. At least one-half of these other mental health staff shall be master's level professionals.
***Substance Abuse Specialist*:** One FTE who has a QP status according to 10A NCAC 27G .0104 and is one of the following: CCS, CCAS, or CSAC.
***Certified Peer Support Specialist*:** A minimum of one FTE Certified Peer Support Specialist. A Certified Peer Support Specialist is an individual who is or has been a recipient of mental health services. Because of life experience with mental illness and mental health services, the Certified Peer Support Specialist provides expertise that professional training cannot replicate. Certified

Peer Support Specialists are fully integrated team members who provide highly individualized services in the community and promote individual self-determination and decision-making. Certified Peer Support Specialists also provide essential expertise and consultation to the entire team to promote a culture in which each individual's point of view and preferences are recognized, understood, respected and integrated into treatment, rehabilitation, and community self-help activities.

***Remaining Clinical Staff*:** The additional clinical staff may be bachelor's level and Paraprofessional mental health workers who carry out rehabilitation and support functions. A bachelor's level mental health worker has a bachelor's degree in social work or a behavioral science and work experience with adults with severe and persistent mental illness. A Paraprofessional mental health worker may have a bachelor's degree in a field other than behavioral sciences or have a high school degree and work experience with adults with severe and persistent mental illness or with individuals with similar human services needs. These Paraprofessionals may have related training (e.g., certified occupational therapy assistant, home health care aide) or work experience (e.g., teaching) and life experience.

Program/Administrative Assistant: One FTE program/administrative assistant who is responsible for organizing, coordinating, and monitoring all non-clinical operations of ACTT, including managing medical records; operating and coordinating the management information system; maintaining accounting and budget records for individual and program expenditures; and providing receptionist activities, including triaging calls and coordinating communication between the team and individuals.

Mid-size teams **serving 51-75 recipients** shall employ a minimum of 8 to 10 FTE multidisciplinary clinical staff persons (in addition to the psychiatrist and program assistant), including 1 full-time master's-level qualified professional team leader, 2 FTE registered nurses (RNs), 1 FTE substance abuse specialist (LCAS, CCS, or CSAC), 1 FTE qualified professional in mental health (preferably with a master's degree in rehabilitation counseling) with responsibility for role as vocational specialist, 2 FTE master's-level qualified professionals in mental health or substance abuse, 1 FTE certified peer support specialist (may be filled by no more than two individuals), 24 hrs per week psychiatrist, and 1 full-time program assistant. Additional positions are based on the needs of the individuals served. Additional staff members shall meet at least qualified professional, associate professional or paraprofessional status.

Smaller teams **serving no more than 50 individuals** shall employ a minimum of 6 to 8 FTE multidisciplinary clinical staff persons, including 1 team leader (MHP), 1 registered nurse, 1 FTE peer specialist, 1 FTE program assistant, and 16 hours of psychiatrist time for every 50 individuals on the team. One of the multidisciplinary clinical staff persons should be a CCS, CCAS, or CSAC.

Rating:

4= Evidence of a full team

2= Evidence of a partial team with additional evidence that attempts have been made to fill vacant positions

0= No evidence of full team present and no evidence that attempts have been made to fill vacant positions

FROM Date is 7/1/10, TO date is date there is evidence of a full team or audit date.

COMMUNITY SUPPORT TEAM

Staffing Requirements

CST shall be comprised of three full-time staff positions as follows:

• One full-time equivalent (FTE) team leader who is a Licensed Professional who has the knowledge, skills, and abilities required by the population and age to be served (may be filled by no more than two individuals). A provisionally licensed or board-eligible Qualified Professional actively seeking licensure may serve as the team leader conditional upon being fully licensed within 30 months from the effective date of this policy. For provisionally licensed team leaders hired after the effective date of this policy, the 30-month timeline begins at date of hire.

AND

• One FTE Qualified Professional who has the knowledge, skills, and abilities required by the population and age to be served (may be filled by no more than two individuals).

AND

• One FTE who is a Qualified Professional, Associate Professional, Paraprofessional, or Certified Peer Support Specialist, and who has the knowledge, skills, and abilities required by the population and age to be served (may be filled by no more than two individuals).

For CST focused on substance abuse interventions, the team shall include at least one Certified Clinical Supervisor (CCS), Licensed or Provisionally Licensed Clinical Addiction Specialist (LCAS), or Certified Substance Abuse Counselor (CSAC) as a member of the team.

The Team Leader shall meet the requirements specified for Licensed or Provisionally Licensed status according to 10A NCAC 27G. 0104 and have the knowledge, skills, and abilities required by the population and age to be served. Persons who meet the requirements specified for Qualified Professional, Associate Professional, or Paraprofessional status according to 10A NCAC 27G .0104 and who have the knowledge, skills, and abilities required by the population and age to be served may deliver CST services.

The **Certified Peer Support Specialist** shall be an individual who is or has been a recipient of mental health or substance abuse services and is committed to his or her own personal recovery. A Certified Peer Support Specialist is a fully integrated team member who draws from his or her own experiences and knowledge gained as a recipient to provide individualized interventions to recipients of CST services. The Certified Peer Support Specialist validates the recipients' experiences and provides guidance and encouragement in taking responsibility for and actively participating in their own recovery. Certified Peer Support Specialists also provide essential expertise and consultation to the entire team to promote a culture in which each individual's point of view and preferences are recognized, understood, respected, and integrated into treatment, rehabilitation, and community self-help activities.

Note: Supervision of CST staff is covered as an indirect cost and therefore should not be billed separately as CST services.

The CST maintains a maximum caseload of 45 individuals per team. The recipient-to-staff ratio is no more than 15:1. The team caseload will be determined by the level of acuity and the needs of the individuals served. CST is designed to provide services through a team approach, and not individual staff caseloads. Factors to consider in determining the number of individuals to be served include but are not limited to the needs of special populations (persons who are homeless, those involved in the judicial system, etc.), the intensity of the needs of the individuals served, individual needs requiring services during evening and weekend hours, and geographical areas covered by the team. The following charts set forth the additional activities included in this

service definition. These activities reflect the appropriate scopes of practice for the CST staff identified below.

Community Support Team

Team Leader

- Provides individual therapy for recipients served by the team
- Behavioral interventions such as modeling, behavior modification, behavior rehearsal
- Designates the appropriate team staff so that specialized clinical expertise is applied as clinically indicated for each recipient
- Provides and coordinating the assessment and reassessment of the recipient's clinical needs
- Provides clinical expertise and guidance to the CST members in the team's interventions with the recipient
- Provides the clinical supervision of all members of the team for the provision of this service. An individual supervision plan is required for all CST members except the Team Leader
- Determines team caseload by the level of acuity and the needs of the individual served
- Facilitates weekly team meetings of the CST
- Monitors and evaluates the services, interventions, and activities provided by the team

Team Leader or Qualified Professional

- Provides psycho education as indicated in the Person Centered Plan
- Assists with crisis interventions
- Assists the Team Leader with behavioral and substance abuse treatment interventions
- Assists with the development of relapse prevention and disease management strategies
- Coordinates and oversees the initial and ongoing assessment activities
- Develops the initial Person Centered Plan and its ongoing revisions and ensures its implementation
- Consults with identified medical (for example, primary care and psychiatric) and non-medical providers, engages community and natural supports, and includes their input in the person centered planning process
- Ensures linkage to the most clinically appropriate and effective services including arranging for psychological and psychiatric evaluations
- Monitors and documents the status of the recipient's progress and the effectiveness of the strategies and interventions outlined in the Person Centered Plan

Associate Professional, Qualified Professional, or Team Leader

- Provides psycho education as indicated in the Person Centered Plan
- Assists with crisis interventions
- Assists the Team Leader with behavioral and substance abuse treatment interventions
- Assists with the development of relapse prevention and disease management strategies
- Participates in the initial development, implementation, and ongoing revision of the Person Centered Plan
- Communicates the recipient's progress and the effectiveness of the strategies and interventions to the Team Leader as outlined in the Person Centered Plan

Paraprofessional

- Provides psycho education as indicated in the Person Centered Plan
- Assists with crisis interventions
- Assists the Team Leader with behavioral and substance abuse interventions
- Assists with the development of relapse prevention and disease management strategies
- Participates in the initial development, implementation, and ongoing revision of the Person Centered Plan
- Communicates the recipient's progress and the effectiveness of the strategies and interventions to the Team Leader as outlined in the Person Centered Plan

Certified Peer Support Specialist

- Serves as an active member of the CST, participates in team meetings, and provides input into the person-centered planning process
- Guides and encourages recipients to take responsibility for and actively participate in their own recovery
- Assists the individual with self-determination and decision-making
- Models recovery values, attitudes, beliefs, and personal action to encourage wellness and resilience
- Teaches and promotes self-advocacy to the individual
- Supports and empowers the individual to exercise his or her legal rights within the community

***All staff providing CST services shall have a minimum of 1 year of documented experience with the adult MH/SA population. (Exception: A Certified Peer Support Specialist is not required to demonstrate 1 year of documented experience in working with the adult MH/SA population, as his or her personal experience in MH/SA services fulfills that requirement.)
Family members or legally responsible persons of the recipient may not provide these services for reimbursement.

Rating:

4= Evidence of a full team
2= Evidence of a partial team with additional evidence that attempts have been made to fill vacant positions
0= No evidence of full team present and no evidence that attempts have been made to fill vacant positions

FROM DATE is 7/1/10, TO date is date there is evidence of a full team or audit date.